



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARVIN VAN HAL MD

Respondent Name

CITY OF DALLAS

MFDR Tracking Number

M4-17-0126-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

September 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...this claim was denied for extent of injury. This claim was billed incorrectly, it was a billing error which was corrected in May; but was denied. I resubmitted the claim again, but it denied again for timely filing. I have no choice but to submit this claim to the Texas Department of Insurance, since I have tried submitting this claim to TriStar with all the documents needed to get this claim paid."

Amount in Dispute: \$200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 23, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 17, 2016	99213 and 99080-73	\$200.00	\$132.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
7. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Is the requestor entitled to reimbursement for CPT Code 99213?
3. Is the requestor entitled to reimbursement for CPT Code 99080-73?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: "29 – The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.0272(b) provides that:

Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
 - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
 - (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
 - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted documentation finds the following: The requestor submitted three copies of EOB's, the first EOB is dated received by the insurance carrier on March 30, 2016 and denied by IMO with denial reason code "219-Based on Extent of Injury." The requestor states in relevant part, "...this claim was denied for extent of injury. This claim was billed incorrectly, it was a billing error which was corrected in May; but was denied..." The second EOB is for the audit of the "corrected" bill and is dated received by IMO on June 21, 2016 and contains denial reason code "29 – The time limit for filing has expired." The disputed date of service is March 17, 2016 and the insurance carrier's received date is June 21, 2016, this date is within the 95-day billing requirements set forth in 28 Texas Administrative Code §133.20(b). The third EOB (reconsideration EOB) is dated received by IMO on August 16, 2016 and contains denial reason code "18-Exact duplicate claim/service."

Review of the submitted documentation supports that the provider submitted a "corrected" bill to the insurance carrier (IMO) with the 95 days as required by 28 Texas Administrative Code §133.20(b). As a result, the Division finds that the disputed services are reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement for CPT Code 99213 rendered on March 17, 2016. Review of the documentation for the office visit supports the billing of CPT Code 99213. As a result, reimbursement is recommended for the disputed service.

Per 28 Texas Administrative Code 134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

Procedure code 99213, with service date, March 17, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.772 is 0.05404. The sum of 2.06059 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$117.08. The Division finds that the requestor is therefore entitled to reimbursement in the amount of \$117.08.

3. The requestor seeks reimbursement for CPT Code 99080-73 rendered on March 17, 2016. Review of the DWC Form-73 supports the billing of CPT Code 99080-73. As a result, reimbursement is recommended for the disputed service.

Per 28 Texas Administrative Code 129.5(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows:

- (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section..."

The Division finds that the requestor is therefore entitled to reimbursement in the amount of \$15.00 for CPT Code 99080-73.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for CPT Codes 99213 and 99080-73 rendered on March 17, 2016 in the amount of \$132.08. As a result, the amount ordered is \$132.08.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$132.08 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	November 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca d' ésta correspondencia, favor de llamar a 512-804-4812.